MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
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COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
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RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Options for modifying Medicare benefits
-- Anne Mutti, Ariel Winter

MR. WINTER: Good afternoon. We will be reviewing the final chapter in the report which presents an array of options for addressing the limitations in the benefit package. Many of these options have been discussed elsewhere in other contexts by other organizations but we thought it would be useful to have them all in one place with a discussion of their trade-offs relative to a common set of criteria. We do not recommend any specific proposals.

We will also be presenting some modeling we have done of a comprehensive benefit package and its effects on total spending and spending by different groups of beneficiaries.

We recognize that there are limited resources for improving the benefit package so we ask if there are better ways of allocating existing resources spent on beneficiaries' health care. Some improvements, such as some cost sharing changes, could be made without significant increases in Medicare spending. Other changes, such as adding drug coverage would require more Medicare spending but may decrease spending by beneficiaries and supplemental insurers. Such reallocations could improve financial protection and access to care for beneficiaries and overall system efficiency, but they may or may not increase current total health spending, as we will see later.

We will discuss the key criteria for evaluating the options to improve the benefit package. Then we will explore three groups of options: changing Medicare's cost sharing rules, expanding Medicare to cover additional benefits, and replacing the current package with a more comprehensive benefit package, which is where we'll talk about our modeling results.

Here are the key criteria we used to evaluate the options. The first is financial protection. Does this option improve protection for beneficiaries and their families from financial difficulty due to high health care liabilities?

The second is access to quality care. Does this option improve access to high quality health care, including preventive, diagnostic, and treatment services in the most appropriate settings?

The third is efficiency. Does the proposal promote the purchase of appropriate care at the lowest cost, and does it improve administrative efficiency for the system as a whole?

Feasibility. What are the challenges in implementing the option? Would it cause major disruptions to beneficiaries, providers, and payers, and how could we manage those disruptions?

And the last one is cost implications. Would the proposal require additional Medicare spending? If so, could it be implemented without increasing total spending on beneficiaries' health care?

Now we'll move on to evaluating the trade-offs of specific proposals. First we discussed potential changes to Medicare's cost sharing structure. As we discussed last time, these options

include reducing the inpatient deductible, increasing the Part B deductible, combining the two deductibles, and eliminating the deductible on blood.

One could also modify the coinsurance structure, for example, by eliminating the inpatient hospital copayment, adding copayments for home health and clinical lab services, and reducing coinsurance on outpatient hospital and outpatient mental health services.

One could consider adding a cap on beneficiary liability for covered services. You discussed earlier the possibility of tiering benefits. Capping liability for beneficiaries with high medical costs is one way of doing that.

The fourth is modifying supplemental coverage so that it exposes beneficiaries to modest cost sharing while still protecting them from high out-of-pocket costs.

Last time we presented to you various combinations of cost sharing changes that illustrate the trade-offs between financial protection, access to care, efficiency and costs. We showed that it is possible to make some changes that improve the cost sharing structure without significantly increasing Medicare spending.

The second section of the chapter examines proposals to expand the benefit package to address concerns in six key areas. This is the same list that you saw in the previous presentation by Mae. The first is prescription drugs. We explore ways to improve access to drugs by expanding Medicaid and state-based programs, offering new Medigap options, reducing drug prices, or covering drugs under Medicare.

Under care coordination we talk about covering case and disease management services to improve care for fee-for-service beneficiaries with chronic illnesses.

We also talk about expanded coverage of preventive services, improved coverage of mental health care, improved coverage of vision and hearing, and dental care. The last two categories we haven't, at this point we don't have much discussion of that in the chapter but we're going to be expanding on that for the next draft.

Now long term care had been on that list and I wanted to explain why it dropped off. We decided to drop it because it's beyond the scope of the report and we didn't think we could really give it the attention that it really requires in the time and the space that we have, so that's why it fell off. We didn't just forget about it. We do realize it's a very important issue.

Now the third section of the chapter explores the option of replacing the current benefit package with a more comprehensive package that would include cost sharing changes and drug coverage. Ideally, this approach would provide all beneficiaries with a core fee-for-service package that better meets their needs than the current package. This approach could improve financial protection and access to care for beneficiaries and make the current system more efficient by reducing demand and need for supplemental coverage, which is associated with higher administrative costs and it's first dollar coverage, which leads to greater use of services.

Here we'll explore some of the key design issues and we did

this last time so I'll do this fairly quickly. The first is the scope of the benefit package. Can we make the package broad enough to include features that beneficiaries now obtain through supplemental coverage, such as drug coverage and limits on liabilities, without increasing total system costs?

The second is, should the package be offered as an alternative to the existing benefit package or as a substitute?

The third is, should it be administered by CMS or by private plans?

Finally, what proportion of higher Medicare costs should be borne by beneficiaries versus taxpayers? This is particularly important given limited federal and beneficiary resources.

So we decided to model the impact of an illustrative comprehensive benefit package on current spending on beneficiaries' health care as well as its effects on different groups of beneficiaries. So this slide shows the features of the package we modeled comparing each feature to current law. These elements should seem familiar to you from the cost sharing illustrations we presented last month.

These features include a combined Part A and B deductible of $400, and out-of-pocket cap on covered services of $3,000, no inpatient hospital copays or limits on days of a stay, a home health copayment, a modified skilled nursing facility copayment of $55 per day, no cost sharing on preventive services, reduced coinsurance on outpatient mental health and outpatient hospital services, and prescription drug coverage, which includes a $500 deductible, 50 percent cost sharing up to $6,000 in total spending after the deductible, 25 percent cost sharing between $6,000 and $10,000 in total spending after the deductible, and no cost sharing after $10,000 in total spending after the deductible.

For the purpose of this model we assumed there would be mandatory enrollment in the new package. That is, there would not be a choice of a high option versus a standard option or the current option. And we did not specify whether the package is administered by CMS or by private plans. We essentially assumed that spending would be the same under either approach. That's for the convenience for the modeling, not because we assumed that would necessarily be the case.

MR. FEEZOR: On the drug component, primarily retail as opposed to any sort of mail order?

MR. WINTER: We assumed that there's 10 percent cost savings from a more tightly managed benefit than the way beneficiaries currently obtain their drugs. So there would be some formularies or bulk discounts and those kinds of things.

One of the model's most important assumptions is the extent to which beneficiaries continue to purchase or be provided supplemental coverage. In large measure, this assumption drives whether total spending on health care goes up or down, because supplemental coverage has higher administrative cost than Medicare and often covers Medicare's deductibles and coinsurance, which increases use of services. If beneficiaries reduce demand for supplemental coverage in response to a comprehensive package there could be lower administrative costs and lower use of

service, which could help offset additional Medicare spending. Because of uncertainty about this assumption we decided to vary it to illustrate a range of possible responses.

In the first scenario we modeled we assumed that all beneficiaries who currently have supplemental coverage would keep it, and supplemental insurers would cover the same percent of beneficiaries' cost sharing as they currently do. Because such cost sharing would decline under this new package, because Medicare is covering more, supplemental insurers would spend less money.

In the second scenario we assumed that only 25 percent of beneficiaries with employer-sponsored coverage and Medigap would keep it and that all beneficiaries with other types of supplemental coverage, such as Medicaid, would keep what they have. We decided to only vary the share that participates in Medigap and ESI because people with Medigap may decide they no longer want to buy supplemental coverage for the more limited liability they would have under the comprehensive package, and because employers may decide to reduce coverage and subsidize the higher Medicare premium that beneficiaries would be likely to pay. We thought that Medicaid would be likely to continue coverage for all beneficiary cost sharing as it currently does.

Before we get into the modeling results I want to caveat our findings. In addition to the supplementation assumption we've made many assumptions that drive the results, such as the current distribution of supplemental spending, administrative costs, and induction effects. Thus, there's a high degree of uncertainty around the results, so please keep that in mind.

This slide highlights the main effects of scenario one, which is the continued participation in supplemental coverage, compared to current law. To reiterate the point of the exercise, all beneficiaries would have access to a better fee-for-service core package. There would be significant shifts in spending. Because Medicare would cover more and beneficiaries would continue to retain their supplemental coverage, beneficiary cost sharing would decline relative to current law. Spending by supplemental insurers would go down, probably causing supplemental premiums to go down. Medicare spending would increase because it's covering more benefits. And Medicare premiums would increase.

Now if all of the higher Medicare spending were financed entirely by beneficiary premiums then the increase would be about $125 per month. This would more than triple the current Medicare Part B premium. Assuming that supplemental premiums would decline, these savings could be used to help pay this additional Medicare premium. Because beneficiaries would maintain their supplemental coverage in their scenario there would be minimal administrative savings. There would also be increased used of services due to broader Medicare coverage and continued supplemental coverage. These two factors would cause an increase in total system costs, which we'll see on the next slide in our approximate terms.

This table illustrates the spending shifts I was just describing. Please keep in mind, as I said before, these numbers

are rough estimates. This table compares approximate 2002 spending on beneficiaries' health care under current law and scenario one. It divides spending into health care outlays, which are direct spending on goods and services and administrative costs incurred by Medicare and supplemental payers. Thus it doesn't separately show financing sources such as premiums or taxes.

If you're interested, the supplemental premiums would be reflected in the supplemental coverage payments and administrative costs, and the Medicare premiums paid by beneficiaries would be reflected in Medicare payments and administrative costs and similarly, taxpayer contributions to Medicare.

As we noted earlier, beneficiary cost sharing and supplemental coverage payments would decline while Medicare spending would go up. Most of the additional Medicare spending, about $50 billion, is attributable to the drug coverage. Administrative costs would decline slightly because supplemental spending declines, and the total spending would increase by about 4 percent in this illustration.

Now the impact of this new package on individual beneficiaries would vary by their current supplemental coverage and use of services. We'll highlight some of the impacts of scenario one on different groups of beneficiaries. Those without any supplemental coverage would obtain better coverage at a higher Medicare premium. Beneficiaries with Medigap and employer-sponsored insurance would have higher Medicare premiums, probably lower supplemental premiums, and lower cost sharing.

Employers could decide to subsidize the higher Medicare premium for their retirees, using money they save on the supplemental coverage. Similarly, states could use the money they save on Medicaid to subsidize the higher Medicare premium for dual eligibles.

Now we'll move on to the results of scenario two in which 25 percent of beneficiaries with Medigap and ESI keep their coverage. The direction of the shifts in spending are similar to scenario one, with the exception that beneficiary cost sharing stays about the same as it is currently. This is because many beneficiaries who had supplemental coverage no longer have it, and are exposed to greater cost sharing.

Spending by supplemental insurers would go down, even more than under scenario one, probably causing a larger decline in supplemental premiums. Medicare spending would go up, but it's a smaller increase than in scenario one. This is because beneficiaries are exposed to more cost sharing which causes them to use fewer services.

While Medicare premiums would increase, it would be a slightly smaller increase than in scenario one, about $100 per month, which still would triple their current Part B premiums.

DR. BRAUN: Could I ask a question? Is this by $100 or to $100?

MR. WINTER: By $100, to $154 per month.

Because many beneficiaries would reduce their supplemental coverage in this scenario there would be some administrative

savings and reduced use of currently covered services although use of prescription drugs would increase. This would result in slightly lower total system costs than under current law.

This is a similar table to what we showed for scenario one. It illustrates the shift in spending I've just described. As you can see, beneficiary cost sharing would stay about the same, supplemental coverage payments would decline, Medicare spending would go up but it's a smaller increase than in scenario one, administrative costs would decline, and total spending would decrease slightly by about 1 percent.

This slide looks familiar because the impacts of scenario two on different groups of beneficiaries are similar to the effects of scenario one. The only difference is with regards to beneficiaries with Medigap and ESI. In particular, these beneficiaries would have higher cost sharing than under current law, whereas in scenario one they have lower cost sharing. This is due to the reduction in supplemental coverage for this group of beneficiaries. These beneficiaries would have higher Medicare premiums, but not as high as in scenario one. And they would probably have lower supplemental premiums than under current law, and lower than in scenario one.

Now for the bottom line to all this modeling. What we think this shows is that it's possible to introduce a more comprehensive Medicare benefit package without increasing current total spending, but it depends on whether beneficiaries and employers reduce supplemental coverage. Moreover, the impact on beneficiaries would vary according to their use of services, their current type of supplemental coverage, and how much of the additional Medicare spending they would be required to finance.

It's also important to note that because this proposal would substantially redistribute spending there's significant feasibility issues, such as how to manage the disruptions to providers, payers, and beneficiaries.

So that concludes my portion of the presentation. We'd like to get your feedback on the tone and content and organization of the chapter.

MS. ROSENBLATT: Tone could use a little work. It wasn't bad but there were some instances where it could be improved.

Was any sensitivity -- these assumptions that you've made can really swing things. Would it be difficult to run some sensitivity analyses just to see what kind of changes some of your assumptions make?

MR. WINTER: In terms of beyond the supplementation assumption that we modified?

MS. ROSENBLATT: Yes.

MR. WINTER: We could do that. Do you have suggestions?

MS. ROSENBLATT: I'd need to give it some thought.

MR. WINTER: Sure, we could look into that.

DR. BRAUN: I just wondered, all the options are sort of a snapshot at a one-year interval. I'm presuming here you're talking, also as you did in the others, with indexing to Medicare spending. I wonder whether it would be helpful to have at least some projection out ahead, because Medicare spending probably will be increasing faster than people's income, than the per

capita income increase. So I think that's --

MR. WINTER: We considered originally doing a five-year estimate. We ran into problems about predicting such things as trends in supplemental coverage when there's evidence that that is declining, at least the generosity of benefits are declining. It just quickly got very complicated, so it was beyond the time we had available for this kind of illustration. But in the text, describing it we can talk about how future trends would affect these approximate costs for 2002.

DR. BRAUN: Good. That might be enough to make people aware of that differential that will occur.

MR. SMITH: Ariel, Anne, I found this very helpful. Let me make sure I understood it and then I have a few --

You've assumed that 100 percent of the reduction in employer-paid insurance and Medigap paid premiums would end up being paid, or the offset would end up being paid out-of-pocket by beneficiaries. I'm reading that correctly?

MR. WINTER: That's right.

MR. SMITH: It seems to me then that there is an important missing piece of analysis here which is the distributional consequences of that across beneficiaries, income groups, and probably age as well would be important to look at. That will be very unevenly distributed when measured against the ability to fill in the gap between the current Medicare premium and the implied new premium.

Just back 30 seconds to long term care. Let's at least say we realize it's important and we didn't talk about it, rather than simply let it evaporate.

I want to come back to a point that Carol made earlier. The discussion of the insurance model or the inappropriateness of the first dollar model on page 6, it's troublingly phrased. I think it's descriptively right. But we're not simply concerned here with an insurance model, we're concerned that the structure of the system encourage people to get medically necessary coverage.

To the extent that copays, higher copays for what you describe as discretionary services, because they aren't randomly distributed, I think misses the point here. The need for those services is not randomly distributed; it's universal. We don't want the payment system to treat those as if they were botox injections for 50-year-olds. This discussion suggests that everything that's not randomly distributed catastrophic is discretionary, and therefore, easy to forgo. I know that's not what you mean but it's the way that that paragraph reads.

Lastly, I'd like us to at least think about -- and we've talked about this in an awkward way a little bit, but the notion that we would take a look at the current net pot of money on the table. Then we'd say we're going to hold it constant, but we're going to shift responsibilities from employers to beneficiaries in that case, and from relatively well-off beneficiaries who can afford Medigap to relatively poor beneficiaries who can't. It's a troubling construct and I think if we're going to use these scenarios, as the text gets rewritten I think we need to acknowledge some concern with both those aspects of the way we've distributed costs looking at the alternatives.

MR. HACKBARTH: Could I just pick up on David's point. I agree with the basic point that the distributive implications of this are maybe one of the most important questions here and they need to be dealt with a little bit more fully and clearly in the text.

DR. ROSS: Two quick things. One is just I'll pass along a suggestion from Professor Newhouse who actually wanted some frequency distributions to show some of these distributional swings between current law. I think that's something we could probably do in the time available.

The other piece, David, responding to your point, is that again there's not a policy direction intended in these. I'll take your point that we just need to be careful with the language. But this was much more illustrative of, given the funds that are now in the pool, how else might they be spent to generate a benefit package? It wasn't in any way intended to suggest a redistribution from shareholders to --

MR. SMITH: I understand, but it will inevitably -- it has that potential effect. We want to make sure we acknowledge the ways in which this is discussed.

MR. HACKBARTH: You run the risk, if you don't discuss explicitly the distributive issues that -- it's a little too glib to say, there's just this pool of dollars out there and we'll take it and use it more rationally. It misses a great big point if that's all the further your discussion goes.

DR. LOOP: Ariel, you may not be able to answer this but these options have some effect on the dual eligibles and there would be some cost shifting, I assume.

The other question that I had is, in just the presentation of the chapter each option, you're supposed to discuss the criteria that you pointed out on page 4, financial protection, access, and so forth. I didn't think that was done consistently with each option. As you present the option you might think about putting it in an inset, in a box in the chapter as you go along and then also summarizing it at the end as you've done.

DR. BRAUN: Floyd hit on one of the things because I was wondering about the impact on Medicaid of this situation because of the shift. But also I was wondering, in line with that, whether this would require a higher subsidization, whether the level for subsidizing deductibles, for instance, would have to rise a little bit with that deductible going up and so forth.

MR. FEEZOR: Just to underscore I think David's point about reflecting on the distributional not only within income groups within retirees, but as you said, between employee and employers because that will be, inevitably, any push on the debate.

Second is, I guess as I looked at those criteria, and this gets back to Medicare, a theme that you've heard me say probably ad nauseam, Medicare is the single biggest determinant in terms of how health care is delivered in this country. We really do an excellent job of saying, okay, this is basically reallocating dollars and protections, or current dollars against perceived needs. We say, what are their potential inflationary cost impact within the use of that? But there is not a criteria, do any of these models have any significant, or that we might conjecture,

have a different impact on how health care is actually delivered itself?

I don't know whether that may be beyond the scope, but ultimately I think that's a public policy question that I hope Congress would at least think through or pay some homage to.

MS. RAPHAEL: I just wanted to also underscore the point that Floyd made. When I read this, at the end of the day I had a hard time understanding what it all meant. Since change is always alarming I think that we need to somehow tie it together, whether we go back to the criteria and analyze the options. But from the stakeholders point of view, for most beneficiaries if you do scenario one, what do they gain, what do they lose? From the point of view of the public taxpayer, what do they gain, what do they lose?

I somehow felt that that was hard to discern, because you talk about it more at the end from an insurance model rather than from the point of view of the stakeholders and their interest in increased financial security, increased access, whatever.

MS. ROSENBLATT: I brought up twice today an issue that nobody else has jumped on, so let me bring it up for the third time because it probably belongs in this chapter. The name of the chapter is, Options for Changing the Medicare Benefit Package. We're focusing on vision, dental, coordination of care, but we're not focusing at all on moving the basic fee-for-service program to a managed care program. There's nothing that I found in the chapter at all on that.

I don't know if any other commissioner feels that it would be nice to have that in there. I personally think it would be an interesting -- at least a paragraph on that. There's another set of ways to change the program that involve what I would call managed care concepts, choice of provider, things like that. So that's comment one.

Comment two, much more particularly, in this chapter there was a discussion of what current employers provide. I think that's where I had the most objection to the looking backwards at what has been provided as opposed to the looking forward as to what's going to happen with greater cost sharing. The other point I want to make there is, there's a big difference between what large employers provide and what small employers provide. If you were to look at that, you'd see that someone that works for a small employer is probably paying a lot more in the way of cost sharing. So always doing a comparison against the large employers that have tended to provide to rich benefits may not be the appropriate balancing factor.

MR. FEEZOR: And who are increasing less a part of the labor market.

MR. SMITH: And large and small, generally the largest employer in the country provides virtually no health care. The old notion of the big industrial firms and the small service sector no longer describes the economy. But you are right, the distribution of what employers provide varies widely.

MS. MUTTI: On Alice's first point talking about managed care and introducing some of those topics, I think something that we struggled in in writing this too is where we can just focus on

benefits and when we start bumping into payment and other incentives. We've tried to draw a line sometimes, but I don't know that we've captured it just right, but that was one thing that was factored into our --

MR. HACKBARTH: In other contexts, not with regard to this report but in other contexts completely separate I think we've alluded to the difficulty that the government has in selecting among providers for a variety of legal and political reasons. At least implicitly, if not explicitly, said that that's what the M+C program is about. If in fact there are beneficiaries who are willing to give up their free choice of provider in exchange for gains in efficiency passed on to them via increased benefits or lower out-of-pocket costs, whatever, that's the way to do the managed care piece as opposed to in the traditional program.

Not that that's the only way to think about it, but that's certainly the way I've thought about it.

MS. ROSENBLATT: I guess I'm thinking you could have a fee-for-service plan where any doctor willing to accept the fees is in it, or maybe you've got two fee schedules -- maybe you've got a tiering of doctors in here. There are two fee schedules, and that would affect benefits. If there are two fee schedules and the benefit, there's a lower copay for the doctors that are paid the lower fee schedule, it's still a fee-for-service plan, I think, and it's also affecting benefits.

I guess I'm just thinking about stuff like that.

DR. BRAUN: I think I was trying to differentiate between the comprehensive benefit package and the method of delivery, which is sort of where you were coming from. But I realize that this comprehensive benefit, in order to get to some figures they've got the copays outlined and so forth. Whereas you could visualize the benefits would all have to be but the payment could be different.

DR. REISCHAUER: My guess is that as the value of supplemental insurance declines and the fixed cost of marketing, et cetera, stay high you would get a tremendous fall-off in a scenario like this in the insurance. Even your scenario two probably has too much supplemental insurance in it. That would be point one.

Point two is, is the Medicaid number, I mean the people who are in Medicaid number a net one that counts for the federal government saving in Medicaid payments? Because you could probably lop a couple billion dollars more off of the net federal cost.

MR. WINTER: We haven't estimated that because -- going back to the table, it's basically a matrix of outlays that is the source of payment for those services, like a flow of funds kind of thing. So the monies flowing through Medicaid we don't show savings for any of the groups financing --

DR. REISCHAUER: There would be VA savings, or there would be Medicaid savings --

MR. WINTER: Yes, there would be.

DR. REISCHAUER: So what I'm just thinking, I thought this was very well done and I congratulate both of you on it. I just thought that the numbers would be lower if one was looking at the

federal liability. Now maybe Murray from his days as a cost estimator will disagree.

DR. ROSS: I guess I'm not quite clear on what federal savings. When the feds expand the benefit package that drives down the states spending, and the feds go from 57 percent to 100 percent. We go from 57 percent of that to 100 percent of it.

DR. REISCHAUER: But if we're counting 100 percent in this table here, I'm just asking --

DR. ROSS: Is that a net.

MR. HACKBARTH: The first point that Bob made about the likely impact on the supplemental market is an interesting one. Those marketing costs, those fixed costs, if you will, will become larger, a significantly larger share of what the people are buying. How did you arrive at the assumption in scenario two?

MR. WINTER: We picked the extreme optimistic end of what the response in supplemental demand would be.

MR. HACKBARTH: Optimistic being?

MR. WINTER: Optimistic being there would be maximal decline in participation because the comprehensive benefit package would fill people's basic needs and they wouldn't have the need any more to go out and purchase a supplemental product or have one provided to them. So we thought that was the extreme of what would be feasible. But now I'm hearing Bob say, maybe we haven't gone far enough; we could go farther. It wasn't a scientific estimate. It was just one we thought would be one end of the range, but we could reconsider that.

MR. HACKBARTH: Of course another way, not necessarily an mutually exclusive way is to say, in order to make it a wash you have to assume this much change in supplemental. Then an optimistic scenario would be something larger than what's in scenario two.

DR. ROSS: In deference to Alice we won't call it optimistic.

MS. MUTTI: In effect that's what ended up happening, too. We pulled the number out of the air a little bit but it did come very close to saying, at a minimum you have to have that kind of behavior.

DR. REISCHAUER: What's going to be left is largely cost sharing for prescription drugs for those who don't have catastrophic prescription drug expenditures. That's going to be a lot of people with chronic conditions which are rather predictable. So this is really going to be prepayment with a service charge on top of it. There's nothing wrong with that. As Bea pointed out, it's like laying away for a Christmas club plan or something and some people like to do that.

MR. WINTER: Also the Part B coinsurance would be left too under this comprehensive package.

MR. MULLER: Just in thinking about this presentation broadly compared to what one might have done seven, 10 years ago, the fact that we're focusing so much on what beneficiaries, consumers pay, what the share is between what the government pays versus private markets, compared to let's say 10 years ago where we looked more at price control on providers, on managed care

systems, and efforts to use both professional scrutiny and administrative scrutiny as a way of controlling utilization service. I'm not saying it's relevant to this chapter but just kind of looking at -- sometimes we have the danger of saying at the current point that we're at is what's going to be the line for the next four, five years.

I think in the same way that maybe in '95 when a lot of people thought that capitation would sweep the American universe without realizing what the reaction to capitation then was, and it came apart pretty quickly, whether by '98 or 2000 or whatever. I think in the same sense, to assume that putting a lot of cost sharing on beneficiaries or on employees is going to be incredibly popular is not something that I expect to happen.

So I know what Wellpoint is trying to do and where they've been a leader, and the article in Health Affairs just recently by Jamie Robinson pointing out all the various efforts to shift these costs to employees. But my sense is that there's the same unwillingness to take on those costs as there was unwillingness to take on the constraints of gatekeeping and managed care and so forth.

So I think this is a very fruitful exercise and I think you've done an excellent job of going forth on this, but I would not be surprised if two years from now these scenarios of how much we're going to shift costs to beneficiaries or employees are dramatically thrown out and a rebellion against that as well.

DR. REISCHAUER: And the alternative?

MR. MULLER: I think we're all struggling with that. As I saying to some of you at lunch having -- maybe I've spent too much time in England this year, but the interesting debate over there between what share of this is done in the public sector versus the private sector, at least in the case of the Blair government recently making the decision they're going to put it all in the public arena versus, as in the U.S., France, and Germany having significant set of sharing between the private and the public.

My sense is that the efforts to -- you definitely know that where people have a lot of ability to vote and a lot of ability to -- in fact the employers, as they do in our system, they're going to rebel against any efforts to put a big burden on them as individuals. So my sense is the burdens are going to go back to institutional sectors, whether it's doctors as groups or insurers as groups or government as groups. But I think we're going to move back towards institutional controls versus trying to put it on individuals, but that's worth the price of a cup of coffee.

DR. REISCHAUER: What amazed me about this actually was that under scenario two, for less than the cost of the average Medigap policy now you get an unbelievably richer package and much greater protection. It struck me, if you're willing to pay $111 or whatever it is now for something that doesn't cover drugs, why not $100 for something that does?

MR. SMITH: Again, I thought this was terrific and very helpful. I think we need to be careful to write it in such a way that the discussion that we engender doesn't become, gee, is a $10 home health copay the right number, or is this the right drug

design?

I think you said, Ariel, that all of this was somewhere in the public domain. It might be useful to cite each of it, just to distance -- so we don't own this package piece by piece. The import of it is much greater if we can think about it as a package rather than we recommend. It will inevitably, if we're not enormously -- maybe inevitably even if we are enormously careful, but we should be real careful.

MR. WINTER: Yes, we've tried to emphasize throughout that these are illustrations and you could select different levels of copayments. We can go back and look at that again.

For prescription drugs, the plan we've modeled is similar to one of the Democratic proposals in Congress. But we chose not to make it identical because we didn't want to get into competition with CBO about scoring an actual piece of legislation. So we varied it a little bit, but we can make reference to its similarities.

DR. NELSON: This intersection between a benefit decision and a coverage decision that I referred to before is relevant in discussions about the prescription drug benefit. If we decide there will be a prescription drug benefit then the next question is what prescription drugs will be covered, how will they be selected? There's enormous elasticity in the cost depending on whether it's bare bones or whether we decide to cover Claritin for everybody or botox.

MS. RAPHAEL: I think David's point is very important. Somehow we just have to try to avoid the SNF industry being concerned because you're raising the amount there, the home health care industry, the Medigap sector, et cetera. Somehow, if we go to what Bob said at the bottom line, which is you take the total pot, you're shifting how some of those dollars are spent, you can really gain so much more That needs to be the message.

MR. HACKBARTH: Okay, good job.